IHCP bulletin

INDIANA HEALTH COVERAGE PROGRAMS BT202046 APRIL 21, 2020

IHCP COVID-19 Response: IHCP temporarily revises PA policy for LTAC and AIR facility admissions

Effective for dates of service (DOS) on or after April 21, 2020, and through the duration of the public health emergency for coronavirus disease 2019 (COVID-19), the Indiana Health Coverage Programs (IHCP) is instituting temporary changes to the prior authorization (PA) requirements for long-term acute care (LTAC) and acute inpatient rehabilitation (AIR) facility admissions.

Prior authorization requirements

For LTAC and AIR admission PAs, providers will only be required to submit basic information using the *IHCP Prior Authorization Request Form*, also known as the universal PA form (available from the *Forms* page at in.gov/medicaid/providers) or electronically through the managed care entity (MCE) provider portal or the IHCP Provider Healthcare Portal (Portal).

The following information remains required on the PA form (or electronic equivalent):

- Rendering provider number
- Rendering provider tax ID
- Rendering provider address
- Member ID (also known as RID)
- Member name
- Member date of birth
- Start date of request
- Stop date of request
- Procedure, service, or revenue code
- International Classification of Diseases (ICD) diagnosis
- Preparer name
- Preparer phone number
- Number of units
- Signature

For authorization of the initial admission, clinical documentation is not required with the PA form, but may still be submitted to allow for care coordination support. All documentation must be maintained by the provider to substantiate the services provided and be available for postpayment review. Documentation must clearly identify the location of the provider and patient. All services rendered must be medically necessary and within the provider's applicable licensure and scope of practice, including recent changes due to the public health emergency.

Providers must submit the PA request within 72 hours, or 3 calendar days, of the member's admission and will receive a confirmation response from the MCE with which the member is enrolled, or from DXC Technology for services delivered under the fee-for-service (FFS) delivery system.

Authorizations will be approved for a period of 14 days. For continuation of services beyond 14 days, a new fully completed authorization form with clinical documentation must be submitted by the provider to DXC or the member's MCE for utilization management review.

Please refer to the *Inpatient Hospital Services* provider reference module for information on billing and reimbursement.

QUESTIONS?

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